Henderson Family Dental

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Dallas, TX 75206
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Patient Registration and Dental/Medical History Form

____
PRINT FULL NAME (First, Full Middle Name, Last Name)

____
STREET ADDRESS

____
CITY STATE ZIP

( )
____
DATE OF BIRTH PHONE NUMBER SCHOOL NAME (If applicable)

Parent/Legal Guardian Information

___Mother ___Father ___Stepmother ___Stepfather ___Grandmother ___Grandfather ___Other: ________________________________
Full Name (First): ______________________ (Middle): ___________ (Last): ____________________Nickname: __________________
Street Address: ____City: __________________ State: _____ Zip: __________
Home Phone: _____________________ Cell Phone: ___________________________ Work Phone: _______________________
Email Address: ________________________________ Social Security Number:___________________ Birth Date: _______________
Place of Employment: ____ Occupation:____

Emergency Contact Information

Full Name: ____Relationship: ________________________________
Street Address: ____City: ____________________ State: ____ Zip: _________
Home Phone: _______________________ Cell Phone: ___________________________ Work Phone: _______________________

Primary Insurance Information

Subscriber: _________________________ Subscriber ID Number: ___________________________ Group Number: ________________
Insurance Company Name: ____ Phone Number: _________________________

Secondary Insurance Information

Subscriber: _________________________ Subscriber ID Number: ___________________________ Group Number: ________________
Insurance Company Name: ____ Phone Number: _________________________

How did you hear about us?

Internet: ____ Patient Referral: ____
Other: ____

Dental History

Purpose of this appointment: _________________________________ Problems/Concerns: ___________________________________
Date of Last visit: _________________ Previous Dentist: ____
Has your child complained of any dental pain? __Yes __No Explain:____
Has your child had any unhappy dental experiences? __Yes __No Explain:____
Has your child had any injuries to his/her mouth/teeth/head? __Yes __No Explain:__________________________________
Does your child thumb/finger-suck /nail-bite /mouth-breath / snore? __Yes __No Explain:___________________________
Does your child nurse/use a bottle/sippy-cup/pacifier? __Yes __No Explain:_______________________________________
Does your child have any unusual speech habits? __Yes __No Explain:____
Does your child have any jaw issues (clicking/popping/pain)? __Yes __No Explain:__________________________________
Does your child wear any orthodontic (braces) appliances? In the past? __Yes __No Explain:_______________________

Dental Hygiene/Dietary History

Do you assist your child with tooth brushing? __Yes __No
How many times per day does your child brush? ____
Does your child use fluoridated toothpastes? __Yes __No
Does your child use a manual or an electric brush? ____________
Do you assist your child with flossing? __Yes __No
How many times per week does your child floss? ____
Does your child drink fluoridated water? __Yes __No

Does your child take fluoride supplements? __Yes __No
If Yes, Type of Fluoride: ___________________________________
Does your child eat snacks between meals? __Yes __No
Does your child drink juice/milk between meals (excludes water)? __Yes __No
What is your child's favorite meal? ________________________
What is your child's favorite snack? ________________________

Medical History

Pediatric Office Name: ____________________________ Doctor's Name: ___________________________ Date of Last Visit: ___________
Street Address: ____________________________________ City: ___________State: ___ Zip: __________ Phone: ______________________
Is your child currently under a doctor's care for a specific reason? __Yes __No Explain: ____
____
Is your child currently taking any medications? __Yes __No Explain: ____
____
Does your child have any emotional/mental conditions we should be aware of? __Yes __No Explain: ________________________________
____
Does your child have any physical conditions we should be aware of? __Yes __No Explain: ____
____
Does your child have any medical conditions we should be aware of? __Yes __No Explain: ____
____
Is your child allergic to any medications? __Yes __No Explain: ____
Does your child have any other allergies (food/animals/latex/etc)? __Yes __No Explain: ____
Has your child ever been hospitalized? __Yes __No Explain: ____
Has your child had any surgeries? __Yes __No Explain: ____
Does your child require pre-medication before dental treatment? __Yes __No Explain:____
Has your child ever had or been diagnosed with any of the following?

__AIDS/HIV
__Anemia
__Arthritis
__Asthma
__Autism
__Bladder Infection
__Bleeding disorder
__Cancer
Type:____________

__Cerebral Palsy
__Chronic Sinus
__Convulsions/Seizure
__Diabetes
__Eating Disorder
__Epilepsy
__Fainting
__ADD/ADHD

__Hearing Loss
__Heart Murmur
__Heart Valves
__Hemophilia
__Hepatitis A/B/C
__Herpes
__Kidney Infection
__Liver Infection

__Measles
__Mononucleosis
__Mouth Sores/Ulcers
__Organ Transplant
__Rheumatic Fever
__Sensory Integration Disorder

__Shunts _VA _VV _VP
__Thyroid
__Tuberculosis
__Venereal Disease
__Syndrome
Type:_____________

Is there any other information that we need to be aware of regarding your child that has not yet been covered in this form? __Yes __No
Explain: ____
____

Appointment Policy

Your child's scheduled appointments are reserved specifically for your child. Any late arrivals or missed appointments affect many patients, including your own child's appointment. It may be several weeks before we are able to reschedule the appointment.

- If a cancellation is unavoidable, please call our office at least **24 hours in advance** so that we may give your child's appointment time to another patient. If a cancellation is made with less than 24 hours' notice, this may be considered a missed/failed appointment.

- If you fail to arrive for your child's scheduled appointment without notice, this may be considered a missed/failed appointment.

- Please arrive at least 5 minutes early for your child's appointment. If you arrive late for your child's appointment, it may need to be canceled due to scheduling restrictions. This appointment may be considered a missed/failed appointment.

- All patients must be accompanied by a parent or legal guardian. If you are unable to accompany your child and do not provide written notification of another person's authorization to make medical decisions, we will not be able to perform any other procedures, aside from what your child is scheduled for that day.

- **Three missed/failed appointments** may result in the termination of our dentist-patient relationship.

I understand that the information given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in my child's medical status, insurance, and contact information. I understand the late/canceled/failed appointment policy.

Printed Guardian's Name: ____

Signature: ____

Date: ____